PEDIATRIC COMMITTEE
OF GOVERNOR'S EMS AND TRAUMA ADVISORY COUNCIL (GETAC)
OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS)
MEETING Minutes
August 16, 2012 (10:30am)

Call to Order: (Charles Macias, MD, Chair)

1. Roll call and Introduction of new members

   Present: Macias, Brown, Hatstein, Jaquith, Juarez, Lewis, Snow, Walker
   Absent: Devillier, Sainz

2. Committee liaison reports (will ask to report on August meeting):

a. Air Medical: Jorge Sainz

b. EMS: Verne Walker: Met yesterday. No specific pediatric issues.

c. Education: Charles Jaquith: Meets this afternoon. In between was discussing transition courses but no pediatrics

d. Injury Prevention: Deb Brown

e. Medical Directors: Juan Juarez: Met yesterday. No pediatric issues. Pandemic and catstrophic events—specific to peds is how to allocate ventilators. 6,000 in state so discussion for dispersion. Utah field triage questions as model but not pediatric ready. Should be localized. Look at current at free standing emergency centers—how EMS transports to one of these from the field.

f. Stroke: Julie Lewis: Nothing pertinent to pediatrics. Presentations from SETRAC. DSHS report to be made public. DNV or Joint commission acceptance.

g. Trauma Systems: Sally Snow: Continue to review rule changes based on proposals. Consensus reached on recommendations presented. Trauma CME discussed. Discussion on Trauma Registry with stakeholder buy in. Registry validation and plan for involving RACs. Courses for nurses and CNE related to ENA (reverification courses) so no ANCC reverification courses after Nov.

h. Regional Advisory Council chairs: Britton Devillier:

i. Disaster planning: Bonnie Hartstein: Development of national health security card in concept phase that includes up to 30 data points regarding medical history but due to lack of funding not being implemented. Transportation/evacuation of children from/to hospitals. Fielded discussion on AM busses so addressing logistics (ex isolettes). Better to transport less sick kids.

3. Update on Child Fatality Review Teams update: Susan Rodriquez; Tabled

4. Position paper on minimizing radiation: Charles Macias

Introduced Jerry Cogburn who works with Environmental and Consumer Safety section, Mammography Inspection Group of TDSHS. The position paper was read and edited. The final version will be proposed to GETAC for final endorsement.

5. EMS for Children State Partnership update: Anthony Gilchrest and Manish Shah

a. Update and review on prehospital evidence summaries: to provide summaries of clinically relevant questions to managing pediatric patient in the prehospital settings so that communities could create their own protocols. Utilized stakeholder input. TCH Evidence Based Outcomes Center was used to develop summaries through literature searches and GRADE evaluations.

Cervical Spine Immobilization: Risk factors for cervical spine injury that can be used to create a selective spinal immobilization protocol? Moderate quality evidence with strong recommendation. For any of listed criteria, patient should be immobilized.

For stable alert patients do benefits outweigh harm of physiological issues and/or psychological injury secondary to forced immobilization? Very low evidence with Strong Recommendation. When cervical collar placement has the potential to result in more neck movement than no immobilization at all., then alternative means to minimize spinal movement during transport or no immobilization.

For pedi patients with suspected CSI, what are most appropriate, children younger than 8 with elevation of the back or an occipitally recessed backboard to optimize neutral positioning. Low evidence with weak recommendation.

Can EMS providers accurately apply criteria in the field: providers should use established risk criteria

Non traumatic shock. For hypovolemic shock, rapid delivery of initial fluid boluses (isotonic fluid in aliquots of 20 ml/kg IV or IM) improve quality of care. Very low quality of evidence with strong recommendation. Same for septic shock management.

For profound septic or hypovolemic shock, does fluid bolus alter quality: IO route is recommended if IV route cant be initiated in a timely manner. Very low evidence with strong recommendation.

Post resuscitation management, how does intubation compare with BVM is preferred to improve outcomes Very low quality evidence with weak recommendation.

Therapeutic hypothermia: non neonate (infant or child), is not recommended in the post resuscitation management. Low quality evidence and strong recommendation. For the neonate, there is better evidence, less than one month old., therapeutic hypothermia is recommended. Evidence quality moderate and strength of recommendation is strong.

Pulse oximetry monitoring not recommended in the term infant but is in the preterm for gestational age less than 32 weeks to titrate oxygen delivery to gradually achieve an oxygen stat of 90-99% Very low evidence with strong recommendation.

Does the use of online physician consultation in prehospital non transport effect outcomes? Very low quality evidence with weak recommendation. Has some benefit in decreasing inappropriate transports so physician consult should be sought when available.

Are the non transports more at risk: decision should be initiated by the parent. Provider should have final decision. Strong recommendation with moderate evidence.

For those that refuse transport, are those more at risk for having been abused? Low quality evidence with weak evidence. In general not more at risk of abuse unless already suspected. Does non transport increase risk. Consider online recommendation. Very low evidence with weak recommendation.

Disseminate information? Online through EMSC website. Stakeholders on the listserve. Will ask for endorsement of medical directors. As a program, will do one topic a year. Topic determination from stakeholders. TCEP.

Important that the value and preferences be stated in the translation of knowledge into protocols.

b. Report on on-line control survey: Cross sectional survey to all medical directors. 40% for directors, over 80% for providers. Pediatric calls for online medical direction: Avg # are 12 calls in urban areas and 4 in the rural areas. They make up 21% of all calls for online medical control. Disproportionate to number of pediatric transports. Providers noted their designee is the primary source of control in 55%. When others do medical direction, directors reported that almost 50% don't know skill training of the person providing. 43% noted that med control physician would not know protocols. 13% of the time the advice contradicts the written protocol. 79% of directors felt that EB regional pediatric protocols would improve quality and 73% felt that PEM online control would improve quality. Directors perceived barriers: in varied protocols and varied EMS provider certification to improving quality of online control. Common barriers is communication with a physician availability. The alternate director may be a problem. Pediatric OLMC use is higher than EMS pediatric transports. Regionalized standardized protocols (EBM) are strongly supported by directors and providers.

6. Public comment: Christine Reaves. RACs should be involved in the dissemination strategies. Dr Moore from Tyler: is anyone looking at risk severity for measuring when CTs for traumas are being obtained—the answer is that data does not appear to be published.

7. Summary of charges
Policy statement to go to GETAC.

8.. Future meetings

Feb 2013 Discussion for implementation bundles and metrics of protocols
Nov 2012 Matrix for society partners and tools suggested for implementing decrease

Respectfully submitted by Charles Macias